THE ADMINISTRATION'S RESPONSES TO QUESTIONS ABOUT THE

STATE CHILDREN'S HEALTH INSURANCE PROGRAM

July 29, 1998 -- Fifth Set

COVERAGE

69. Question: What immunization, well-baby and well-child care benefits should Title XXI plans include?

Answer: With respect to immunizations, State CHIP plans must include coverage of all immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) in accordance with the periodicity schedule prescribed by that body. These immunization requirements are identical to the requirements that apply in both Medicaid and the Vaccines for Children (VFC) program.

With respect to well-baby and well-child care, we strongly encourage States, in designing their well-baby and well-child care coverage under CHIP, to adopt the benefits and periodicity schedules that are recommended in the American Academy of Pediatrics (AAP) *Recommendations for Preventive Pediatric Health Care (*Pediatrics, August 1995, vol 96:2, pp 373-374) and the American Academy of Pediatric Dentistry (AAPD) *Reference Manual* (Pediatric Dentistry, Special Issue, 1997-8, vol 19:7, pp 71-72), and further described in *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* (Green M., (Ed.). 1994). These guides are models of coverage and care that are appropriate to the specific needs of children, reflect consensus in the professional community about appropriate clinical practice, and enjoy the strong support of advocates for children's health.

70. Question: How will HHS define well-baby and well-child care services for purposes of the prohibition on cost-sharing outlined in Section 2103(e)(2) of Title XXI?

Answer: As consistent with Medicaid regulations, all cost-sharing on services provided to children is prohibited in standard Medicaid CHIP expansions. For purposes of the cost-sharing prohibition that applies in non-Medicaid CHIP programs, HHS has adopted the definition of well-baby and well-child care that is used by the American Academy of Pediatrics (AAP) and incorporated in the FEHBP Blue Cross and Blue Shield (BCBS) benchmark plan, and the definition of routine dental services that is used by the American Academy of Pediatric Dentistry (AAPD).

Accordingly, in non-Medicaid CHIP programs, all the well-baby and well-child services below are subject to the prohibition against cost-sharing under Section 2103(e)(2):

- All healthy newborn inpatient physician visits, including routine screening (inpatient or outpatient);

- Routine physical examinations, laboratory tests, immunizations, and related office visits as recommended in the AAP's *"Guidelines for Health Supervision III"* (June 1997), and described in *"Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*" (Green M., (ed.). 1994); and

- Routine preventive and diagnostic dental services (i.e., oral examinations, prophylaxis and topical fluoride applications, sealants, and x-rays) as described by the AAPD's *Reference Manual* (Pediatric Dentistry, Special Issue, 1997-8, vol 19:7, page 71-2).

Note that this cost-sharing prohibition applies equally to fee-for-service and managed care delivery systems.

71. Question: Does the Mental Health Parity Act of 1996 apply to Title XXI?

Answer: Yes. States choosing to offer non-Medicaid CHIP programs that include coverage of mental health services must comply with the Mental Health Parity Act (MHPA) regulations. States choosing to offer Medicaid CHIP programs must comply with the parity regulations for Medicaid managed care plans. These requirements are discussed below. Parity regulations are not an issue in fee-for-service Medicaid programs because there are no limits on mental health benefits. (For further information, see the State Medicaid letter dated January 20, 1998, seventh in a series of letters that provides guidance on the implementation of the Balanced Budget Act of 1997. This letter is available on the Internet at www.hcfa.gov.)

Section 4704(a) of the BBA creates a new section in the Social Security Act (1932(b)(8)) that requires each Medicaid managed care organization to comply with certain requirements added to the Public Health Service Act by the MHPA, Public Law 104-204. MHPA provides for parity in the application of certain dollar limits on mental health benefits when limits are placed on medical and surgical benefits.

MHPA was enacted on September 26, 1996, and provides that a group health plan, or health insurance coverage offered in connection with a group health plan (as those terms are defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA)), providing both medical and surgical benefits and mental health benefits may not impose an aggregate lifetime dollar limit or annual dollar limit on mental health benefits unless it also imposes such a dollar limit on substantially all of the medical and surgical benefits. If the plan does impose an aggregate lifetime limit or annual limit on substantially all medical and surgical benefits, the plan can only impose a comparable limit on mental health benefits that is less than or equal to that applied to the medical and surgical benefits. If a group health plan offers two or more benefit package options under the plan, the requirements of MHPA apply separately to each option. MHPA makes clear that the requirements of the law apply to group health plans and health insurance issuers offering

coverage under such plans, regardless of whether the mental health benefits are separately administered under the plan.

Group health plans and health insurance coverage offered in connection with group health plans are not required by MHPA to provide mental health benefits. In addition, the law does not affect the terms and conditions (including cost-sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity) relating to the amount, duration, or scope of mental health benefits under a plan or coverage, except as specifically provided in regard to parity of aggregate lifetime limits and annual limits. Finally, MHPA requirements do not apply to benefits for substance abuse or chemical dependency.

The Department of Health and Human Services, the Department of Labor, and the Department of the Treasury developed interim rules to implement MHPA. These interim rules were published in the Federal Register on December 22, 1997 at 62 FR 66932. Please see these rules for a detailed discussion of the parity provisions. Information is also available on the Internet at: www.hcfa.gov/hipaa/hipaahm.htm.

72. Question: Can a State offer a different benefit package for children who have special needs/physical disabilities?

Answer: If the State has chosen the CHIP Medicaid expansion option, all children must receive the same benefit package because of the Medicaid comparability requirement.

In non-Medicaid CHIP programs, States may offer different benefit packages for children with special needs. The State can define the benefit package under Section 2103 to include supplemental services for children with special needs/physical disabilities based upon medical necessity. Alternatively, the State may have more than one benefit package that meets all the requirements of Section 2103, including one designed for children with special needs/physical disabilities, as long as the eligibility criteria for that coverage complies with the Americans with Disabilities Act (ADA) requirements for non-discrimination.

If the State offers a limited package of services to address special needs (e.g., a package of long-term care support services) that is not part of comprehensive insurance coverage required under Section 2103, spending for these services would be subject to the 10 percent limitation on funds for other child health assistance.

73. Question: Since Title XXI does not include a definition of "Institutions for Mental Diseases (IMDs)," does the Title XIX definition apply?

Answer: Yes, the Title XIX definition applies. Section 2110(b)(2) excludes from the definition of targeted low-income children a child who is an inmate of a public institution or who is a patient in an IMD. The definition of IMDs in Title XIX regulations at 42 CFR 435.1009 states, in part, that an IMD:

"means a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such."

74. Question: Section 2110(b)(2)(A) of Title XXI excludes from eligibility children who reside in Institutions for Mental Diseases (IMDs). However, Section 2110(a)(10) allows for coverage of inpatient mental health services in CHIP. Would you address this apparent contradiction in the law?

Answer: It is important to distinguish between eligibility under a State program and coverage of services provided under that program.

Under a non-Medicaid CHIP program, the law excludes any child who is a patient in an institution for mental diseases (IMD) from the definition of a targeted low-income child. We view this eligibility exclusion as applying when an eligibility determination is made, either at the time of application or during any periodic review of eligibility (e.g., at the end of an enrollment period). Therefore, a child who is an inpatient in an IMD at the time of application for CHIP, or during any eligibility determination, would be ineligible for insurance coverage under the program.

If a child is enrolled in a non-Medicaid CHIP plan and subsequently requires inpatient services in an IMD, the benefits for IMD services included under the plan would be covered, subject to any limits specified in the plan's benefit package. If the child needs to reside in an IMD, however, eligibility and payment would end at the time of redetermination.

For individuals enrolled under a CHIP Medicaid expansion, the rules governing eligibility and payment for inpatients in IMDs are identical to those governing the State's approved Medicaid plan. Therefore, all otherwise qualified individuals residing in an IMD qualify for eligibility, but IMD services can only be reimbursed if the State has elected to cover such services for the under 21 population in the State's approved Medicaid plan.

STATE PAYMENT PROCESS

75. Question: How are IHS services treated under a non-Medicaid CHIP plan option?

Answer: Under Section 2102(b)(3), CHIP plans must "include a description of procedures to be used to ensure . . . the provision of child health assistance to targeted low-income children in the State who are Indians." In a non-Medicaid CHIP program, States would receive Federal matching payments for expenditures on targeted low-income children, including Native American children, at the State's CHIP enhanced

matching rate. Such payment would count against the State's CHIP allotment. Native American children may be eligible as targeted low-income children, even though they are eligible for IHS services. Section 2105(c)(6)(B) specifically provides that payment may be made under CHIP for covered services provided through programs operated or financed by IHS to children enrolled in CHIP as described in question 76 below.

76. Question: Targeted low-income Indian children can be eligible for both CHIP and IHS-funded services. Which program pays for their care?

Answer: Title XXI does not change IHS authority. Therefore, CHIP-expanded Medicaid and/or non-Medicaid CHIP-purchased health insurance would pay for services that are covered by the CHIP plan and are provided by IHS/Tribal programs participating in the CHIP plan. IHS and IHS-funded Tribal health programs would continue to serve as the "payor of last resort." IHS programs essentially "wrap around" any third party coverage that the individual may have (including CHIP expanded Medicaid and purchased insurance). IHS only pays for items and services not covered by CHIP or other third-party coverage.

The Indian Health Care Improvement Act grants IHS and IHS-funded Tribal programs authority to bill Medicaid and all other third party insurance for services the IHS/Tribal program provides directly to the Indian person. The IHS/Tribal program also may require that health care providers with whom they contract for other services for Indian beneficiaries to bill Medicaid and other health insurance before billing the IHS/Tribal program.

77. Question: Who is eligible for enhanced match under Section 1902(u)(2)?

Answer: Section 1905(b) provides that enhanced Federal matching is available for services provided to children described in Section 1902(u)(2) -- optional targeted low income children. These are children under the age of 19 who meet the Title XXI financial and other eligibility requirements established by the State, do not have creditable health insurance coverage or group health plan coverage, and would not be eligible under the Medicaid State plan in effect on March 31, 1997. Thus, enhanced matching is available for any children in the new optional targeted low-income children's group and also may be available for some children in other Medicaid eligibility groups. For example, if a State expanded a mandatory poverty-level-related eligibility group by adopting less restrictive financial requirements than were in effect on March 31, 1997, enhanced Federal matching would be available for that subset of children made eligible by the expansion who meet all the criteria in the definition at Section 1902(u)(2). To receive the enhanced matching, the State would need to identify those children in the poverty-level-related group who: (1) meet the Title XXI financial and eligibility requirements established by the State; and (2) are eligible only as a result of the expansion; and (3) who do not have creditable health insurance coverage as described under HIPAA.

Enhanced matching is not available for services provided to children who become eligible for Medicaid as a result of a change in the cost-of-living amount, such as in the

SSI program, or a change in the Federal poverty levels. A cost-of-living change does not affect the methods and standards under the State plan; therefore, the children would actually be eligible under the policies of the plan in effect on March 31, 1997.

Example: On March 31, 1997, a State covered all children under age 19 whose family income did not exceed 100 percent of the Federal Poverty Level (FPL) and whose family resources were below $1000. In 1998, the State decides to drop the resource test for the group of poverty-level-related children under age 19 and also to cover the group of optional targeted low-income children with family income between 100 and 200 percent of the FPL. Enhanced Federal matching would be available for services provided to all the children in the group of optional targeted low income children who would not otherwise be Medicaid-eligible in a poverty-level-related or other mandatory eligibility group. Children with health insurance cannot be included in this group. Enhanced matching would also be available for services provided to children in the poverty-level-related group who do not have creditable health insurance or group health plan coverage and whose resources exceed $1000. FFP would be at the regular Medicaid matching rate for children in this group who have insurance or whose resources are below $1000.

78. Question: Who is eligible for enhanced Federal match under Section 1902(u)(3)?

Answer: Section 1905(b) provides that enhanced Federal matching is available for services provided to children described in Section 1902(u)(3) -- children under age 19, born before October 1, 1983, who are eligible under the poverty-level related group of children under age 19 and who would not be eligible for Medicaid under the Medicaid State plan in effect on March 31, 1997. Unlike the children described in Section 1902(u)(2), the children described in Section 1902(u)(3) does include those children with health insurance. Thus, enhanced matching is available for services provided to children under age 19, born before October 1, 1983, whether or not they have health insurance, if they only are eligible under the poverty-level-related group and would not be eligible for Medicaid under the policies in the State plan in effect on March 31, 1997. However, enhanced match for these children phases out as this group becomes Medicaid eligible under current law.

Example: On March 31, 1997, a State did not cover children born before October 1, 1983 under the poverty-level-related group of children under age 19 (nor under an expanded group of qualified children). On March 31, 1997, the State did cover all children under age 19 under the optional group of children whose income and resources met the AFDC requirements. In 1998, the State decides to accelerate the age of the poverty-level-related group and cover all children under age 19 to 100 percent of the poverty level. Enhanced Federal matching is available for services provided to all children in the poverty-level-related group who were born before October 1, 1983, whose income and resources exceed the AFDC levels, whether or not they have insurance but only until the children become eligible for regular Medicaid under current law.

79. Question: Does enhanced Federal matching for a Medicaid expansion under Section 1905(b) terminate if the child is subsequently determined eligible for

Medicaid under the requirements of the State plan that was in effect on March 31, 1997?

Answer: Yes. If the State determines during the eligibility redetermination period that a child is eligible for Medicaid based on the State plan in effect on March 31, 1997, then the enhanced Federal matching terminates for services provided to that child. For example, eligibility based on the State plan in effect on March 31, 1997 would apply if the family's income dropped below the effective Medicaid income level for the poverty level group on March 31, 1997. In that event, Federal matching would revert to the regular FMAP rate.

Please note that under Medicaid regulations, the State must have procedures designed to ensure that recipients make timely and accurate reports of any changes in circumstances that may affect their eligibility. When the State receives information about changes in circumstances, it must promptly redetermine the child's eligibility. If the State has elected the option to guarantee eligibility of the child without regard to changes in circumstances under Section 1902 (e)(12), then eligibility must be redetermined at the end of the guaranteed period.

80. Question: Can a State include the costs of the children enrolled in non-Medicaid CHIP programs when calculating the uncompensated care costs of a hospital for computing the Omnibus Budget Reconciliation Act (OBRA) 1993 hospital-specific Disproportionate Share Hospital (DSH) payment limits?

Answer: Those children insured under a non-Medicaid State CHIP program cannot be counted as uninsured in the calculation of the hospital-specific DSH limit. Also, the shortfall (costs less any CHIP payment) for these children cannot be counted as uncompensated care.

However, if a State is doing a Medicaid expansion that is also referenced in an approved State child health plan, these children must be counted in the calculation of the hospital specific DSH limit. DSH payments made for services (either as lump-sum or service specific) rendered to children in the Medicaid expansion group must be claimed at the enhanced FMAP and are counted against the State's Title XXI allotment. If DSH payments are made unrelated to specific services (for example in a lump sum), the State must work with the HCFA Regional Office to develop an appropriate allocation methodology to allocate a portion of the DSH payments to the Medicaid expansion group so that they are appropriately claimed at the enhanced FMAP and are counted against the State's Title XXI allotment. Federal payments for such DSH expenditures (based on either the enhanced or regular FMAP) would be counted against the State's Medicaid DSH allotment.

81. Question: When the Medicaid administrative Federal Financial Participation (FFP) rate is greater than 50 percent, how should States claim FFP for Title XIX administrative expenditures related to CHIP Medicaid expansions?

Answer: The Health Care Financing Administration's December 8, 1997 financial letter offered States two options for claiming Federal financial participation (FFP) for administrative expenditures related to the Medicaid expansions. As discussed below, we believe States should have the flexibility to apply either of the two administrative claiming options for administrative expenditures with FFP rates greater than 50 percent. Thus, the State could elect Option 1 for claiming administrative expenditures for which the regular Medicaid FFP rate is 50 percent, and Option 2 for claiming administrative expenditures for which the Medicaid FFP rates are 75 and 90 percent (as discussed below).

Under the Medicaid program, the FFP rate for general administrative expenditures necessary for the proper and efficient administration of the Medicaid program is **50 percent** (Section 1903(a)(7) of the Social Security Act). However, there are other FFP rates for Medicaid administration specified in Section 1903(a) of the Act and referenced in Federal regulations at 42 CFR 433.15 which range from 75 to 100 percent.

In the December 8 all-State letter, States were offered two options for claiming FFP for (CHIP- related) Title XIX program expansion administration expenditures:

Option 1. Under this option, States could elect to claim FFP for CHIP-related Medicaid administrative expenditures at the Title XXI enhanced FMAP rate. As indicated in the December 8 letter, States choosing this option "must continue to claim all such expenditures on the Title XXI expenditure forms until the 10 percent limit and/or the Title XXI allotment is reached." Afterward, expenditures are matched at the regular FFP rate.

Option 2. Under this option, States could elect to claim FFP for CHIP-related Medicaid administrative expenditures under the Title XIX Medicaid program. As indicated in the December 8 letter, States choosing this option for such expenditures "will be reimbursed at the applicable Medicaid administrative matching rate."

Although not explicit, the "applicable Medicaid administrative matching rate," referenced in the December 8 letter refers to the 75 to 100 percent FFP rates as well as to the regular rate of 50 percent. As a result, States should consider their situation in deciding how to seek the administrative match.

Once a State chooses an option, it must consistently apply that option for the entire fiscal year. The State may then change its option at the beginning of the next fiscal year. This is because the CHIP allotment, the 10 percent limit, and the enhanced FMAP rates are all established on a fiscal year basis.

States should indicate their choice(s) for claiming FFP for CHIP related Medicaid administrative expenditures under Option 1 or 2 in their August submissions of the budget reports, either Form HCFA-37 (for the Medicaid program) or Form HCFA-21B (for the CHIP).

82. Question: What are the procurement and prior approval requirements States must follow under CHIP with respect to contracts, including contracts with managed care organizations (MCOs)? Must the State obtain prior approval from the Federal government for sole source procurements?

Answer: Procurement requirements found at 45 CFR Part 92 contain the overall administrative requirements for grants to State and local governments that are applicable to programs administered by the Department of Health and Human Services. Although these requirements are generally applicable to many types of procurements, other regulatory provisions apply to procurements of automatic data processing (ADP) equipment and services. (The requirements related to ADP sole-source procurements are discussed in Question 83.)

Regulations at 45 CFR 92.36(c) require procurement transactions to be "conducted in a manner providing full and open competition." However, these regulations also recognize that competitive procurements may not always be appropriate. Specifically, 45 CFR 92.36(d)(4) allows for procurement on a noncompetitive basis when the item is only available from one source, when a competitive process would cause a delay in a situation where a "public exigency or emergency" exists, when the awarding agency authorizes noncompetitive proposals, and "after solicitation of a number of sources, competition is deemed inadequate." Generally, States utilizing a sole source procurement process for MCO contracts do so on the basis of inadequate competition. Please contact your Regional Office for more details.

With respect to prior approval, the general procurement regulations permit HHS component agencies broad latitude to impose prior approval requirements. We are not requiring prior approval of any contracts with MCOs under Title XXI.

For both procurement and prior approval, HCFA is willing to work with any State that would like to discuss these issues. We encourage States to work with us. It should be noted that HCFA has the right to subsequently review all procurement transactions under HHS grants to ensure that they comply with Federal requirements.

The State could be at risk if the Federal government determines that the State has not met such requirements. Therefore, we believe it would be beneficial for States to work cooperatively with the Federal government prior to the award of any contracts on a noncompetitive basis.

To avoid disallowances, HCFA will seek to advise States during the State plan approval process when it becomes aware of a contracting arrangement which does not comply with Federal requirements, and (if true) will not knowingly approve a plan which relies on such an arrangement.

83. Question: What is the process for using the Medicaid Management Information System (MMIS) under CHIP?

Answer: States have the option of expanding their existing Medicaid program under CHIP or of developing non-Medicaid CHIP programs. Although States must use their MMIS systems if they choose to expand their existing Medicaid program under CHIP, Title XIX enhanced funding is available for system changes to their MMIS. (See requirements under Part 11 of the State Medicaid Manual.) Please note that system changes directly related to eligibility determinations are not part of the MMIS and receive only a 50 percent Federal Financial Participation (FFP), as noted in Part 11.

At their option, States may use their MMIS platform to accommodate their non-Medicaid CHIP needs. States are encouraged to consider using their MMIS systems in developing their CHIP-only programs because it may be more efficient to build upon already existing platforms. However, modifications to the MMIS must be discussed before implementation with HCFA Regional Office staff because of the potential impact upon the MMIS' overall system architecture. Even though such changes are funded only with Title XXI funds, and not with Title XIX, prior approval may still be required due to changes in the scope of the MMIS. The extent to which the MMIS may be altered under such circumstances varies widely. Consequently, States that are contemplating this approach must first discuss the changes they have in mind with our Regional Offices.

84. Question: Must States submit cost allocation plans as required for other programs administered by Health and Human Services for Title XXI administrative costs?

Answer: Yes. Under 45 CFR Part 94, Subpart E, States must submit cost allocation plans which describe the procedures States use in identifying, measuring, and allocating all State agency costs incurred in support of all Federal programs administered or supervised by the State agencies. Therefore, States must include information in their cost allocation plans on both Medicaid expansions and non-Medicaid CHIP programs under Title XXI.

84a. Question: Title XXI seems to contain a very broad definition of outreach. For purposes of cost allocation, what principles should be applied to outreach expenditures?

Answer: Under the provisions of OMB Circular A-87 and the associated regulations, costs that are common to more than one program are generally allocated to the related programs in accordance with the relative benefits received by each program. In general, this principle would apply to administrative costs for the Title XXI program. However, Title XXI provides for an exception to the general cost allocation principle, allowing States some flexibility in claiming FFP for "outreach" activities. Section 2102(c)(1) of the Social Security Act describes "outreach" as:

"Outreach to families and children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs to inform these families of the availability of, and to assist them in enrolling their children in, such a program."

As contained in this description, "outreach" under Title XXI of the Act may include activities for informing about, and assisting in, enrollment in a State's Title XXI program and other public and private health coverage programs. Therefore, we believe States have flexibility in allocating and claiming for the outreach activities specifically described in Section 2102(c)(1) of the Act under two options:

Option 1. Claim the entire costs of such outreach activities under the State's Title XXI program, without having to cost allocate to the other benefitting programs, or

Option 2. Claim the costs of such outreach activities in accordance with the provisions of Circular A-87 and related regulations. This option would require the State to allocate such costs.

Under either option, States must submit a cost allocation plan describing how they allocate administrative costs among the programs. This plan will be evaluated for approval by the Department's Division of Cost Allocation within the Program Support Center. Since cost allocation encompasses several types of programs, this issue is evaluated separately from the CHIP plan approval process. Due to the existence of a separate cost allocation plan review process, there is no need for States also to comment on cost allocation within the Title XXI plan.

85. Question: Can a State do presumptive eligibility (PE) under its State Title XXI program?

Answer: Yes, although there is no express provision for PE under Title XXI, a State may craft an equivalent procedure in a non-Medicaid CHIP program as a health initiative. As such, expenditures provided during the PE period are subject to the 10 percent limit for administration, outreach, health services initiatives and other child health assistance and are initially counted against the State's Title XXI allotment as described in question. A State, however, has the following options for claiming such expenditures:

a. Identify and Claim PE on Ongoing Basis -No Adjustments. The State can identify and claim FFP for all PE expenditures on an ongoing basis (as such expenditures are incurred and claimed to the State) with no subsequent adjustments after the actual eligibility determination. In this case, the amount of the PE expenditures would be applied against the allotment, would be claimed at the enhanced FMAP, and would be applied against the State's 10 percent limit. This approach may be the easiest for States to administer and may be best for those States with sufficient room under their 10 percent cap.

b. Report After Actual Eligibility Determination. The State can wait and report potential PE expenditures after the actual determination of eligibility; in that case expenditures would be classified in accordance with the actual eligibility determination:

- Expenditures for children determined to be eligible for Medicaid are funded at the appropriate Medicaid FMAP (enhanced or regular) and are not subject to the 10 percent limit.
- Expenditures for children determined to be eligible under a State's CHIP are funded at the enhanced FMAP, are counted against the allotment, and are not subject to the 10 percent limit.
- Expenditures for children determined not to be eligible for either program are funded at the enhanced FMAP, are applied against the allotment, and are subject to the 10 percent limit; that is, such expenditures are treated and reported as PE expenditures.

c. Identify and Claim PE on Ongoing Basis -Adjust After Actual Eligibility Determination. The State can identify and claim FFP for all PE expenditures on an ongoing basis, as such expenditures are paid by the State (as would be done in a. above). However, after the actual determination of eligibility is made, adjustments would be made to reflect the actual eligibility category determination. In this case, the amounts of the PE expenditures would be reported on an ongoing basis, applied against the allotment, would be claimed at the enhanced FMAP, and applied against the 10 percent limit. As actual eligibility determinations are made, the State would make adjustments to the previously reported expenditures as in b. above.

86. Question: Can States collect drug rebates under a non-Medicaid CHIP program?

Answer: The Medicaid drug rebate program operates under the authority of Section 1927 of the Social Security Act and requires rebates for individuals eligible under Title XIX. There are no similar requirements for children made eligible only under Title XXI.

A State cannot collect Medicaid drug rebates for individuals eligible under a non-Medicaid CHIP. A State can, however, collect Medicaid drug rebates on behalf of those Medicaid expansion groups described in Section 1905(u)(2) and 1905(u)(3) of the Act and those Medicaid presumptive eligibles under 1920A.

87. Question: In a non-Medicaid State CHIP plan, may States impose premiums on a quarterly or yearly basis? What is the interaction between premiums and enrollment fees?

Answer: Under Section 2103(e)(3)(A), for children in families with income at or below 150 percent of the Federal Poverty Level (FPL), the State child health plan may not impose: "...an enrollment fee, premium or similar charge that exceeds the maximum monthly charge permitted consistent with standards established to carry out Section 1916(b)(1) (with respect to individuals described in such section)..." Section 1916(b)(1) sets out the requirements for cost-sharing under Medicaid for individuals who are not described within the categorically needy eligibility categories or as qualified Medicare beneficiaries. Under the regulations implementing those requirements (42 CFR 447.52),

the maximum charges per month are set forth in a scale (from $1 to $19) based on monthly family income.

These regulations, however, do not describe payment methodologies and do not require a monthly collection process. Therefore, States will be permitted to collect quarterly or yearly charges in CHIP plans, allowing States to reduce the administrative burden of collecting fees. An enrollment fee, in addition to any premium that is imposed, is permissible to the extent that the total cost-sharing amount, allocated on a monthly basis, does not exceed the Medicaid cost-sharing limits specified at 42 CFR 447.52. To assure that these fees do not act as a barrier to enrollment, States wishing to collect premiums on an annual, semi-annual, or quarterly basis are required to provide beneficiaries with the option of paying their premiums on a monthly basis in payments that do not exceed the monthly maximums as described in 42 CFR 447.52.

For example, for a family of three with a gross monthly income of $500, $6 is the maximum monthly charge under 42 CFR 447.52. States would be permitted to bill families for charges that exceed the maximum monthly charge (e.g., quarterly or yearly), as long as the total amount does not exceed the allowable monthly amount multiplied by the periodicity, if the State plan includes an option that would allow the enrollee to pay on a monthly basis. The family in this example could be billed $18 for a 3-month period if the family has agreed to this billing structure, or the family could opt to pay $6 per month over the same quarter. States should refund a pro-rated share should the individual disenroll in the middle of a quarter.

For children in families with income above 150 percent of FPL, cost-sharing (including enrollment fees) must not exceed 5 percent of the family's income for the year. In a CHIP Medicaid expansion, no enrollment fee, premium or similar charge is permitted.

88. Question: For those States that use CHIP funds to subsidize employer-sponsored insurance, can employer contributions for its employees count toward the State match?

Answer: Payments made by employers to health insurance companies cannot be counted as the State matching payment. The State cannot receive a match for payments it does not make (Section 1903(w) of the Act).

89. Question: Can donations from health insurers be used in computing the State match?

Answer: Donations made to a State from health insurers are considered "provider-related" donations. Any provider-related donation made to a State, regardless of whether or not the State uses the contribution for Federal matching purposes, is subject to the statutory provisions of Section 1903(w) of the Act. In order for a provider-related donation to be considered bona fide, and therefore eligible for Federal match, the donation cannot have an indirect or direct relationship to Medicaid payments. It should be noted that the indirect relationships to Medicaid payments include linkages between provider-related

donations and non-Medicaid payments from the State, including CHIP. For further information, please see 42 CFR 433.54(c) of Federal regulations.

90. Question: How does a State assure HCFA that it is using State match that is allowable under CHIP?

Answer: Section 9.10 of the Title XXI State plan application template dated September 12, 1997, requires that the State provide HCFA with details on the sources of the non-Federal share of plan expenditures. HCFA's approval of a State's Title XXI plan is contingent on the State's use of permissible funding sources for the non-Federal share of plan expenditures. Furthermore, HCFA reserves the right to disallow funds, to the extent it finds the State is using impermissible funding for the non-Federal share of plan expenditures under a previously approved plan. For further information, please see 42 CFR 433.54(e).

STATE PLAN DEVELOPMENT

91. Question: When a State chooses the non-Medicaid program option, but offers the same benefit package as in their Medicaid State plan, must the State conduct an actuarial test to determine benchmark equivalence?

Answer: No. A State will not be required to demonstrate actuarial equivalence of its CHIP benefit package to a benchmark plan if it offers the same coverage as it provides under the State's Medicaid State Plan. The Medicaid package will be considered Secretary-approved coverage under Section 2103(a)(4).

A State that has altered or reduced its Medicaid benefit package for children through a Statewide Section 1115 demonstration also will not need to demonstrate actuarial equivalence as long as the benefit package is comprehensive and provided both to the traditional Medicaid and to the expansion population of children in the State or includes full EPSDT services. Benefit packages in approved, existing Section 1115 demonstrations that meet these requirements will be considered as Secretary-approved coverage under Section 2103(a)(4).

92. Question: In July 1997, HCFA requested that State Medicaid Directors consult with Indian Tribes in their State on Section 1115 waivers. Did HCFA request that State Medicaid Directors consult with Tribes on CHIP?

Answer: Yes. Section 2102(b)(3)(D) of the CHIP law requires States to describe in their CHIP plan procedures used to ensure the provision of child health assistance to targeted low-income children in the State who are Indians. Therefore, States are encouraged to consult with Tribes and Indian organizations throughout the process of developing and implementing their CHIP plans, outreach strategies, and other policies and procedures. These are matters of great interest to Tribes and others in the Indian health community and on which they have significant expertise and insight. Experience with Section 1115 demonstrations and other Medicaid issues demonstrates the benefit of early consultation

to identify issues when they can be resolved more successfully. For these reasons, we issued a letter to States on February 24, 1998, on the subject of Indian consultation on CHIP. Informational copies of the letter have been sent to Tribal leaders and Indian organization officials. The letters include a list of Federal agency contact persons for Indian issues, who can assist States, Tribes, and Indian organizations with their consultations upon request.

93. Question: Must States have enabling legislation in place to implement their Title XXI plans before submitting an application?

Answer: When the passage of State enabling legislation is required to implement a Title XXI plan, a State can submit its plan application prior to the passage of the legislation. States are asked to indicate in their application if such legislation is necessary and when it will be in place. States, as part of their application, are asked to include a statement agreeing not to draw down Title XXI funding until the enabling legislation has been enacted in a manner consistent with HCFA's State Plan approval. Additionally, States would be asked to concur that plan changes required as a result of the State legislation would be submitted as a plan amendment prior to program implementation and drawing down Federal funds. States providing this assurance could have their State plan reviewed and approved prior to the enactment of legislation. States that do not agree to these provisions would not have their plans approved.

94. Question: Can the effective date of a CHIP State plan be retroactive to a fiscal year prior to the one in which the State's plan is submitted and approved? For example, if a State submitted and HCFA approved its CHIP plan during FY 1999, could the State receive a FY 1998 effective date?

Answer: Yes, a State's CHIP plan can be effective prior to the fiscal year in which its State plan is submitted and approved and its allotment established, but no earlier than October 1, 1997. Matching payments may be made retroactively only if the plan eventually approved by HCFA is exactly the same as the plan in effect as of the retroactive date. (See question 16(a) released on September 11, 1997 on the risks States' may be taking in this instance.) Note, however, that there are certain special provisions applicable for CHIP State plans approved during FY 1999 and relating to the establishment of allotments for FY 1998 and FY 1999.

Under Public Law 105-174, recently enacted on May 1, 1998, if a State submits a State child health plan during FY 1999, and the plan is approved by HCFA by the end of FY 1999, that is by September 30, 1999, CHIP allotments may be established for the State for both FY 1998 and FY 1999. The effective date for the State plan would be as requested by the State, but no earlier than the beginning of FY 1998, that is October 1, 1997.

For CHIP State plans approved by HCFA after September 30, 1999, (that is during FY 2000 or later), the State's CHIP plan must be approved by HCFA by the end of that fiscal year in order to receive a State CHIP allotment for a fiscal year. For example, if HCFA

approves a State's initial CHIP State plan during FY 2000, the State could only receive a State allotment for FY 2000; the State could not receive an allotment for FY 1998 or for FY 1999. Since the State did not have a child health plan approved by HCFA in FY 1998 or by the end of FY 1999, it would not receive a State allotment for FY 1998 or FY 1999.

Under Section 2106(a)(2)(B) of the Act, States may specify an effective date in their State plans, but no earlier than October 1, 1997. In the example of a State child health plan that is first approved during FY 2000, a FY 2000 allotment would be established, but there would be no allotments for FY 1998 or FY 1999. However, the FY 2000 allotment is potentially available for providing Federal Financial Participation (FFP) for the State's allowable FY 1998 and 1999 expenditures, assuming the State has requested an effective date for its State plan in those fiscal years. Thus, a State may potentially have an effective date for its CHIP plan in a fiscal year for which it does not have a CHIP State allotment.

Note, in order for the State to receive FFP for expenditures related to a retroactive period, the CHIP State plan must comply with all applicable statutory requirements during the retroactive period and meet the requirements and specifications made by HCFA during the approval process for the State plan that was eventually approved. For example, Section 2103(e)(3) requires that cost-sharing for children in families below 150 percent of the FPL be consistent with Medicaid regulations. Therefore, a State that had higher cost-sharing than permitted under Section 2103(e)(3) for children under 150 percent of FPL would result in no retroactive financing.

95. Question: What must States do to meet the Title XXI requirement to involve the public in the design and implementation of their child health insurance programs and to develop a mechanism that will ensure ongoing public involvement once the plan has been implemented?

Answer: States are required under Section 2107(c) of Title XXI to ensure public involvement in the design and implementation of the plan and to ensure a method for ongoing public involvement. Beneficiaries, providers, and interested groups and organizations can provide valuable input in developing a plan and insight into the successes and challenges that arise during implementation and throughout the operation of the program. States can assure such involvement through a wide variety of approaches. Specific examples have been provided in a letter from HCFA, dated February 23, 1998. The plan reviewers will consider the viability of the approaches the State is taking and their appropriateness to each phase of the plan's development and ongoing program operation. States are strongly encouraged to utilize those methods that encourage the greatest participation.

96. Question: What is the relationship between Title V Maternal and Child Health programs and State CHIP programs?

Answer: Title V agencies have a statutory responsibility to assure mothers and children access to quality health care services and to provide and promote family-centered,

community-based, coordinated care. These agencies complement CHIP because Title V provides States with a health care delivery infrastructure and coordinated services focusing on the needs of children and establishing standards of care for children with special health care needs and reporting systems that could enhance Title XXI evaluation.

Title V agencies and States are encouraged to work together during the design and implementation of Title XXI programs in order to augment the activities that Title V agencies are already conducting in the area of child health as well as to share their expertise in this area with the State agency responsible for the Title XXI program.

97. Question: What is the appeals process for a State whose Title XXI plan is disapproved?

Answer: Upon disapproval, a State has 60 days to petition for reconsideration. This is done by submitting a written request for reconsideration to HCFA, as specified in the State's amendment disapproval letter. Until there are final regulations for the CHIP program, the appeals process for CHIP will follow the same process that applies to Medicaid State plans.

ELIGIBILITY

98. Question: How are children of public agency employees defined for purposes of CHIP eligibility?

Answer: For purposes of Title XXI, "children of public agency employees" are children who have a family member who works for a public agency within the State and who are eligible to participate in a State health benefits plan. A public agency may be an agency of the State, county, city or other type of municipal agency. A State health benefits plan is one offered or organized by the State government. Please note that children of public agency employees who work for an agency that does not offer a State employee health insurance plan may be eligible for CHIP. For example, if a local government, such as a county or a city, has its own insurance plan that is separate from the State employee plan, the children of that entity's employees could be eligible for CHIP, as long as they are uninsured and meet all other CHIP eligibility criteria. (For more detail, see Question 54 from the November 26, 1997 set of questions and answers.)

99. Question: Are there any circumstances under which the children of State employees can be covered by CHIP?

Answer: Yes. Although Section 2110(b)(2)(B) excludes children who are eligible for health benefits coverage under a State health benefits plan on the basis of a family member's employment with a public agency in the State, there are two methods by which low-income children of public agency workers can be covered under CHIP.

State Program Option -- This option applies to States that choose to expand coverage through a non-Medicaid CHIP State program. States may cover the children of public

agency employees when there is no employer premium subsidy for any State health insurance coverage option in a particular public agency, assuming the children meet all other CHIP eligibility criteria. HCFA intends to provide further guidance through a regulation specifying a maintenance-of-effort date for States that do subsidize the coverage of dependent children and wish to change their program in order to exercise this option. This is to ensure that States do not change their contributions to make children eligible for CHIP. (Note: There only are a few States that can exercise this option and that the State should consult with their Regional Offices.)

Medicaid Option -- States are permitted to cover the children of State workers at the enhanced matching rate if the State chooses to expand coverage through a CHIP Medicaid expansion, if these children meet all other CHIP eligibility criteria. States may exercise this option because the statute's public agency exclusion applies only to State CHIP programs, not to CHIP Medicaid expansions.

To the extent that a State provides coverage through a private insurer, under Section 2105(c)(6)(A), no CHIP payment is available for child health assistance to a child who would have been served by that insurer but for a provision of its insurance contract excluding children based on eligibility for CHIP assistance. This prevents a State from carving out CHIP children from its State health benefits plan.

100. Question: What types of workers are included in the term "public agency" according to Section 2110(b)(2)(B)?

Answer: Public agency employees include those of a State, county, city or other type of municipal agency including workers for whom the State contracts out. This definition includes, for example, public school districts, transportation districts, irrigation districts, and any other type of public entity.

101. Question: What constitutes a "State health benefits plan," according to Section 2110(b)(2)(B)?

Answer: The definition of a "State health benefits plan" is one that is offered or organized by the State government on behalf of State employees or other public agency employees within the State. It does not include separately run county plans, city plans or other public agency plans.

102. Question: What if some public agencies with access to the State health benefits plan offer a premium subsidy for dependent coverage, while other public agencies with access to the State health benefits plan do not offer a premium subsidy for dependent coverage? Can the children who do not receive subsidized coverage be eligible for CHIP?

Answer: Yes. Children of public agency employees whose families are offered no subsidy for the cost of dependent coverage are not truly receiving a benefit, and thus are not subject to the exclusion pertaining to children who are eligible for health benefits

coverage under a State health benefits plan on the basis of a family member's employment with a public agency in the State. This means that some children of public agency employees with access to State health benefits may be eligible for non-Medicaid State CHIP programs, while others may not be eligible for non-Medicaid CHIP programs, depending on whether or not the parent's public agency employer offers any subsidy for the cost of their coverage.

As noted in Question 99, the children of all public agency employees are always eligible for CHIP Medicaid expansions, assuming they meet other CHIP eligibility criteria.

103. Question: If a teenager is enrolled in a non-Medicaid CHIP program because she is not eligible for Medicaid as a child and subsequently becomes pregnant and, therefore, eligible for Medicaid under the poverty-level-related group of pregnant women, must the State disenroll the teen from the non-Medicaid CHIP program? Which program would be responsible for paying for prenatal care provided prior to Medicaid enrollment?

Answer: If the teen is enrolled in a non-Medicaid CHIP program, then becomes pregnant and thus is eligible as a poverty-level-related pregnant woman under Medicaid, the teen's non-Medicaid CHIP eligibility may end: (1) at the next scheduled redetermination of CHIP; (2) when it comes to the State's attention that the teen is pregnant and eligible under Medicaid such as when a family applies for Medicaid and the child is found eligible; or (3) when a qualified provider determines that teen is presumptively eligible for Medicaid as a pregnant woman (if the State has elected this option). (Of course, if a determination is made that a presumptively eligible pregnant teen is not eligible for Medicaid, she may be eligible for CHIP again.)

A CHIP beneficiary has a right to apply for, and receive, if eligible, Medicaid regardless of the State's practice for determining and reevaluating CHIP eligibility. This is not an option, but a requirement. When the State determines that the individual is Medicaid eligible, she can no longer be considered as CHIP eligible. If, however, the individual does not independently act to change her status, HCFA will not require the State to do so until the State redetermines CHIP eligibility.

In many instances, because the Medicaid benefits package includes pregnancy-related services, it may be more beneficial for the child to be enrolled in Medicaid. Therefore, in those cases, States are encouraged to refer and enroll pregnant teens in Medicaid.

104. Question: Under the Vaccines for Children Program (VFC), how are the costs for vaccines reimbursed for the Medicaid expansion groups (Section 1905(b)) and the Medicaid presumptive eligibles (PEs) (Section 1920(a)), when this Medicaid expansion is also referenced in an approved State child health plan?

Answer: Children in Medicaid expansion groups described in Section 1905(b) and the presumptively eligible described in Section 1920(a) are eligible under the Federal Vaccines for Children (VFC) program. The cost of vaccines provided under the VFC

program to these groups will not be counted against the States' Title XXI allotments. Further guidance on the coverage of immunizations under Title XXI and VFC is contained in a State Health Official letter released May 11, 1998, which can be found on the HCFA website at www.hcfa.gov.

105. Question: Is there any income which MUST be excluded under a non-Medicaid State CHIP program?

Answer: Yes. Certain Federal statutes other than the Social Security Act provide that payments made under that statute must not be considered income or resources in determining eligibility for benefits under any Federal or Federally assisted program or must not be considered income in determining eligibility under any means-tested program under the Social Security Act. Such payments may not be counted as income under a non-Medicaid State CHIP program.

A recent example is Section 421 of Public Law 104-204 which authorized the VA to make payments to children with spina bifida who are born to veterans who served in Vietnam. These benefits may not be considered income under any Federal or Federally assisted program. These payments must be excluded in determining non-Medicaid CHIP eligibility. Other examples include home energy assistance payments or allowances provided under subchapter II of Chapter 94, Title 42 of the U.S. Code, and relocation assistance provided under Title II of the Uniform Relocation Assistance and Real Property Acquisitions Polices Act of 1970.

106. Question: If a State elects a non-Medicaid CHIP program, what legal immigrant children must the State cover?

Answer: A State must cover those legal immigrant children who meet the Federal definition of qualified alien and who are otherwise eligible. The following qualified alien children who are otherwise eligible must be covered:

-- All qualified alien children who were in the United States before August 22, 1996;

-- Refugees, asylees, and certain Cuban, Haitian and Amerasian immigrants;

-- Unmarried, dependent children of veterans and active duty service members of the Armed Forces; and

-- Immigrant children who enter the United States on or after August 22, 1996 as lawful permanent residents and who are in continuous residence for 5 years. (Earliest eligibility for this group will be August 22, 2001.)

Somewhat different requirements apply under Medicaid giving the State the option to deny Medicaid to some of the immigrants who must be covered under a non-Medicaid

CHIP program (e.g., qualified aliens who were in the United States before August 22, 1996). Please see Section 3210 of the State Medicaid Manual.

A State choosing a non-Medicaid CHIP program also may cover battered immigrants as determined by INS and as added by Section 501 of Division C of public law 104-208 to the definition of Qualified Alien in Section 431 of Welfare Reform, provided the immigrant is otherwise eligible for the program.

A more complete policy statement is contained in the State Health Official letter of January 14, 1998, which can be found on the HCFA website at www.hcfa.gov.

Note that this answer clarifies the answer to Question 19(a) on the circumstances when coverage is at State option for qualified aliens who were in the United States before August 22, 1996.

107. Question: What are States doing about limiting substitution, or crowd-out, of private health insurance coverage for public coverage under CHIP?

Answer: Keeping the occurrence of crowd-out to a minimum has been a priority for both the Congress in drafting the CHIP legislation, and for the Administration in working with the States to approve their CHIP plans.

Following is a table that summarizes each of the twenty-four approved CHIP plans as they relate to crowd-out. As you will see, the approved plans give a variety of examples for preventing crowd-out of private health insurance coverage.

Approved CHIP Plans as of 7/16/98

State	Type of CHIP plan	Income eligibility threshold	Description of Crowd-out strategy
Alabama	Medicaid	100% of FPL up to age 19	No separate enrollment from Medicaid. Eligibility system is designed to use data matches and client interviews to ensure that only eligible targeted low-income children are covered.
California	Combination	200% of FPL up to age 19	3 month waiting period
Colorado	Non-Medicaid CHIP program	185% of FPL up to age 17	Ineligible for CHIP if eligible for Medicaid or has other creditable insurance coverage with at least a 50% employer contribution within past 3 months.

Connecticut	Combination	300% of FPL up to age 18	6 month period of uninsurance (may be extended to 12 months)
Florida	Combination	185% of FPL up to age 19	Study and report within 6 months of implementation; if results show crowd-out, will implement a 3 month waiting period with certain exceptions. Re-evaluation at the end of 3 years.
Idaho	Medicaid	150% of FPL up to age 19	No separate enrollment from Medicaid. Children with access to private health insurance ineligible, with certain exceptions.
Illinois	Medicaid	133% of FPL up to age 19	Monitoring
Indiana	Medicaid	150% of FPL up to age 19	Monitoring
Massachusetts	Combination	200% of FPL up to age 19*	Monitoring. If study results show crowd-out, State will implement a 3 month period of uninsurance.
Michigan	Non-Medicaid CHIP program	200% of FPL up to age 19	6 month look-back/waiting period
Missouri	Medicaid	300% of FPL up to age 19	6 month period of uninsurance
New Jersey	Combination	200% of FPL* up to age 19	12 months of uninsurance, with certain exceptions
New York	Non-Medicaid CHIP program	185% of FPL up to age 19	9 month study -- if results show crowd-out, implement either a waiting period or deny children with access to employer based coverage (at least 50% subsidized) or an alternative as later defined by the Secretary.
North Carolina	Non-Medicaid CHIP program	200% of FPL up to age 19 200 to 225% FPL up to age 19; enrollees will be allowed to buy into the program for one year at full cost	Applications will first be processed for Medicaid eligibility. Six month period of uninsurance for eligibility, with certain exceptions. Six months after the program has been implemented, the waiting period will be 60 days.

Ohio	Medicaid	150% of FPL up to age 19	Monitoring
Oklahoma	Medicaid	185% of FPL children born on or after 10/1/83	Survey to determine the extent of dropping existing private coverage due to the availability of CHIP.
Oregon	Non-Medicaid CHIP program	170% of FPL up to age 19	Six month waiting period*
Pennsylvania	Non-Medicaid CHIP program	185% of the FPL through age 16* age 0 to 5	Annual study of crowd-out. If data results show a rate of substitution greater than 12%, State will implement a strategy to prevent further crowd-out. Will seek legislative change if necessary.
Puerto Rico	Medicaid	200% of Commonwealth Poverty Level* up to age 19	Monitoring
Rhode Island	Medicaid	250% of FPL ages 8 through 18	Must not have refused coverage with premiums between $150 and $300/month within the past year.
South Carolina	Medicaid	150% of FPL up to age 19	No separate enrollment from Medicaid. Application includes a question about other health insurance coverage. State will not charge Title XXI for any child with other coverage.
Texas	Medicaid	100% of FPL ages 15 to 18	Monitoring
Utah	Non-Medicaid CHIP program	200% of FPL up to age 19	Every CHIP application will go through the Medicaid eligibility determination process. Must not have voluntarily terminated coverage within three months prior to application for CHIP.
Wisconsin	Medicaid	100% of FPL up to age 18	Monitoring*

*** Corrections as of August 13, 1998**

ADDITIONAL ISSUES

108. Question: In what ways was Title XXI amended by the Washington, D.C. appropriations bill (P.L. 105-100)?

Answer: The following changes were made to the Title XXI program:

(1) Section 1903(f)(4).

- **Add "optional targeted low-income child" to exceptions for limits on FFP**

Technical correction: The new Medicaid category of "optional targeted low-income child" under Section 1905(u) is added to the list of exceptions to the limits on Federal matching in Section 1903(f)(4).

Explanation: Section 1903(f) limits Medicaid payments to individuals in families that are below 133 1/3 percent of the AFDC payment level. A number of eligibility groups, however, have received exceptions from these limits. The original law did not add this eligibility category as an exception under Section 1903(f)(4).

(2) Section 1905(b):

- **Enhanced match for acceleration of coverage of 15-18 years olds under 100 percent of Poverty**

Technical correction: A State's payment made on behalf of children under Section 1905(u)(3) who are 15 to 18 year olds and below 100 percent of poverty who are not eligible under the State Medicaid plan using methodologies and criteria in effect as of March 31, 1997 cannot exceed the State's available allotment.

Explanation: This change limits the amount of enhanced match available for these children to the amount available in the State's CHIP allotment. The original law did not limit expenditures on behalf of children under 1905(u)(3) to the amount of the State's available allotment.

(3) Section 1905(u):

- **Medicaid maintenance of effort.**

Technical correction: The definition of an "optional targeted low-income child" was amended to include a child who would not qualify for Medicaid under a State plan in effect on March 31, 1997.

Explanation: States cannot claim an enhanced match for children who would have been eligible for Medicaid on March 31, 1997. States that expand coverage through Medicaid can receive an enhanced match for children covered through expansions taking effect on April 1, 1997 or after. The original law used a date of April, 15, 1997.

- **Reference to acceleration of coverage of 15-18 year olds below 100% of poverty.**

Technical correction: The reference to this category of children is changed to 1902(l)(1)(D).

Explanation: The original law incorrectly used a reference to Section 1902(l)(2)(D), which does not exist.

- **Exemption from spending limit for Territories.**

Technical correction: The spending limits under Section 1108 for the Territories will not apply to Federal payments made based on the enhanced match under Section 2105(b).

Explanation: Section 1108 sets Medicaid spending limits for the Territories. The original law did not make an exception for Federal payments made under Section 2105(b). This change allows the Territories to use their Title XXI allotments without regard to their Medicaid spending cap.

(4) Section 2104

- **Expenditures must be applied against the allotment on a quarterly basis and in the order in which they are claimed**

Technical correction: State Medicaid expenditures will be applied against the applicable fiscal year allotment based upon the quarter in which they are claimed by the State.

Explanation: The original law required that expenditures be applied against the allotment based upon the quarter in which the State paid the expenditures. This change means that States will not have to revise the available allotments each time they receive a claim for a previous quarter.

- **Federal Allotment Amount.**

Technical correction: The CHIP appropriation for fiscal year 1998 was increased by $20 million to $4.95 billion.

Explanation: The original law provided an appropriation of $4.75 billion.

(5) Section 2105.

- **Applicability of Expenditures to Allotments.**

Technical correction: A new section was added providing States with flexibility in when they submit claims.

Explanation: This change clarifies that States may claim expenditures in a quarter, although they were incurred in a previous quarter. The original bill would have prevented

States from claiming a past year's expenditures in a future fiscal year. This is inconsistent with Congressional intent to have a three-year "carry over" of allotments.

- **Reference to paragraph 5.**

Technical correction: The phrase "Subject to paragraph (5)" is deleted.

Explanation: The original law included a reference to a paragraph 5 that does not exist.

(6) Section 2105(c)(2)(A).

- **Calculation of the 10 percent limit on a fiscal year basis.**

Technical correction: The 10 percent limit (for outreach, administration, direct services and other child health assistance) was amended to be calculated on a fiscal year basis.

Explanation: The original law required the 10 percent limit to be calculated on a quarterly basis. This change will allow States to exceed the 10 percent limit in a particular quarter, as long as this limit is not exceeded when costs are calculated for the entire fiscal year.

- **Calculation of the 10 percent limit on total computable basis.**

Technical correction: The 10 percent limit (for outreach, administration, direct services and other child health assistance) was amended to be calculated based on total computable expenditures (Federal and State).

Explanation: The original law calculated the 10 percent limit based only on Federal expenditures. This change allows States to calculate the 10 percent limit based on the sum of both Federal and State expenditures, not just Federal expenditures.

(7) Section 2110(b):

- **Definition of a "targeted low income child."**

Technical correction: The definition of a "targeted low income child" was amended to include two additional options under Section 2110(b)(1)(B)(ii). First, it added a category for a child whose family income does not exceed the Medicaid applicable income level (determined as if "June 1, 1997" were substituted for "March 31, 1997.") Second, it added a category for a child who resides in a State that does not have a Medicaid applicable income level.

Explanation: The original law included only one category: a child whose family income exceeds the Medicaid applicable income level but does not exceed 50 percentage points above the Medicaid applicable income level. This change provides States with the flexibility to receive enhanced match for children who are above the State's Medicaid applicable income level on March 31, 1997 up to the level of the State's Medicaid

applicable income level on June 1, 1997. It also allows a State without a Medicaid applicable income level to receive enhanced match for children above the State's Medicaid applicable income level on March 31, 1997.

- **Definition of "Medicaid applicable income level."**

Technical correction: First, the date on which the Medicaid applicable income level is based was moved back to March 31, 1997 from June 1, 1997. Second, the definition was amended to add eligibility expansions for "qualified children" under Section 1905(n)(2) as selected by the State.

Explanation: The date change allows States with approved plans to receive enhanced match for expansions after March 31, 1997 rather than after June 1, 1997. The original law defined the term "Medicaid applicable income level" as the effective income level specified under the State Medicaid plan or under Section 1902(r)(2) as of June 1, 1997 for the child to be eligible for Medicaid as a "poverty level child" under Section 1902(l)(2). The second change was needed because some States expanded Medicaid coverage for children through 1905(n)(2) rather than 1902(l)(2).

(8) Section 2110(c)(3)

- **HIPAA citation.**

Technical correction: The citation for HIPAA is changed to Section 2791 of the Public Health Service Act.

Explanation: The original law incorrectly cited Section 2191 of the Public Health Service Act.